Medical Care Advisory Committee

Minutes of Meeting September 17, 2015

Participants

Committee Members Present

Russ Elbel (chair), Andrew Riggle (vice chair), Sarah Carbajal-Salisbury, Kevin Burt, Steven Mickelson, Jackie Rendo, Rylee Curtis, Michelle McOmber (via phone), Danny Harris, Tina Persels, Mark Brasher, Mark Ward, Debra Mair, Jonathan George, Michael Hales

Committee Members Excused

N/A

Committee Members Absent

Jason Horgesheimer, LaVal Jensen, Donna Singer

UDOH Staff

Craig Devashrayee, Eric Grant, Iona Thraen, Matthew Ash, Heidi Oliver, Julie Olsen, David Lewis, John Curless, Jeff Nelson, Julie Ewing, Shandi Adamson, Emma Chacon, Tonya Hales, Kolbi Young, Josip Ambrenac, Summer Perkins, Karen Larson

Guests

William Cosgrove, MD; Doug Springmeyer; Tracy Altman (via phone); Joyce Dolcourt; Jenifer Lloyd; Shawn McMillen; Jessie Mandle; Adam Cohen

Welcome

Nomination of Individuals to Fill Vacancies

There are still seats available on the MCAC for representatives of the business community and long-term care providers. If anyone has nominations, they should contact Russ Elbel, Michael Hales, or Josip Ambrenac. Josip said there is currently a nominee from the Nursing Home Association.

Minutes of June 18, 2015 and July 16, 2015 Meetings

Rylee moved to approve the minutes of the previous meetings. The motion was seconded and passed.

New Rulemakings

Craig Devashrayee reported on the new rulemakings.

Joyce asked, in regard to R414-510, what is the difference between program applicants and eligible individuals? Josip said an individual needs to be residing in a facility for at least 12 months to be considered.

Sarah asked if anything is being addressed in R414-307 (Eligibility for Home and Community-Based Services Waivers) for individuals with chronic disease. Jeff Nelson said there is nothing at this time.

Budget Update

Eric Grant reported on Medicaid Eligibility Growth:

- Adult enrollment increased in June, July and August. These increases are possibly due to the ACA (additional open enrollment for tax penalty) especially given that Utah's most current unemployment rate is 3.6% (the US is 5.3%). The most recent numbers from the Conference Board shows that Utah is one of nine states where the number of unfilled jobs is larger than the number of unemployed. We expect growth in adult enrollment to level off in the near future.
- Child enrollment has also been increasing in spite of Utah's economic growth. This growth is also largely attributable to the ACA. One ACA effect is connected to the tax penalty. Another is CHIPicaid. In the pre-ACA reality, economic growth was accompanied with increased CHIP enrollment and declining Medicaid enrollment. Under the ACA, children who would have been enrolled in CHIP a few years ago are now Medicaid eligible.
- People over Age 65 enrollment growth depends on a combination of population growth and economic conditions. As such, given Utah's improving economic conditions, the rate of growth in this group is expected to be positive but at a declining rate in the near future.
- People with Disabilities enrollment growth like the elderly is dependent on a combination of population growth and economic conditions. And, like the elderly, the rate of growth in this group is expected to be positive but at a declining rate in the near future.
- Pregnant Women enrollment has been declining since May. One factor is declining pregnancies among Utah's teens. Another contributing factor may be due to an ACA provision that allows individuals to be covered under their parents' health insurance until age 26.
- CHIP enrollment has largely stabilized since March and is expected to remain so in the near future.
- PCN enrollment has been declining given that the evaluation process is now month-to-month rather than annual. Furthermore, PCN eligibility has changed from 150% FPL to 95% FPL, which reduces the pool of possible eligibles.

RyLee asked how close we are to closing open enrollment for PCN. Michael said we are not close. RyLee asked whether there is an opportunity to open PCN for adults without children. Michael replied that the waiver has a cost neutrality provision; adults without dependent children are a higher-cost group. The waiver has a construct of 2:1 for adults with children, so we will need to see how many more adults with children come on first. We are at 50/50, and are trying to get back closer to the 2:1 ratio. It would most likely be a very limited enrollment if this happened.

SIM Grant Update

Iona Thraen gave an update on the SIM grant.

Utah received a smaller award than we applied for. $2M was awarded on February 1, draw down was approved on June 10. UDOH is currently working with nine contractors; about 70% of the funds have gone out to the community. There was an official kickoff on September 10 to talk about behavioral health integration, end of life planning, obesity and diabetes. Doing an environmental scan to focus on value based purchasing and delivery transformation. On July 10 there was a meeting to talk about internal Health Information Technology planning.

The group is engaged with Envision Utah with Greg Bell. Envision Utah focuses on wellness and obesity.

Russ Elbel asked how the All Claims Payer Database was involved. Iona said that was listed as a past success, but not as a current activity.

Russ asked what the process will be for behavioral health integration. Iona said the group is developing a series of independent innovations that can be taken back to the Feds for support for individual cases. There is a planning group led by Dr. Chuck Norlin of UPIQ. Russ Elbel asked what the target groups are. Targeting age group of 0-34, and high school-34. Looking at best practices and then would move ahead proposals. The grant goes through 7/14/16. Will be asking for no-cost extension because of the late start this year. Contact Iona if interested in participating.

ICD-10 Updates

Matthew Ash reported on the progress of the migration to ICD-10.

We are currently two weeks away from go-live (10/1/15). This will affect all HIPAA-covered entities that submit claims. Matthew's team is confident that they're ready for go-live. Michael said that, contrary to what is being said in the public, CMS did not delay implementation of ICD-10. The CMS exceptions apply to Medicare only. All Medicaid claims must comply with ICD-10.

Internal testing started in March of this year. External testing started in July. The testing has gone smoothly, identifying and resolving minor issues. Testing with hospitals, clinics, nursing homes, labs, and third party vendors has taken place. The goal has been to make the transition as seamless as possible. There has been outreach to providers to offer help and education. Articles for providers were published in April, July and August. Had state-wide training in July, during which time the readiness of providers was monitored. There is provider outreach in conjunction with UHIN that is geared toward providers who still need assistance. We will continue to test as long as we need to. If providers are interested in continuing to test, contact utahmedicaidicd10@utah.gov.

Steven asked how long after 10/1/15 a provider be able to submit a claim under ICD-9. Matthew said providers will have up to one year to submit claims with a date of service prior to 10/1/15. Claims with dates of service 10/1/15 and after will need to be submitted under ICD-10.

Quality Measures Workgroup

Heidi Oliver and Julie Olsen gave an update on the Quality Measures Workgroup (aka Quality Improvement Council). Their slides are attached to these minutes.

25 quality measures, including HEDIS/CAHPS measures.

Heidi reviewed the slides. Overall the workgroup was pleased with the performance of the ACOs. In 2015 they have worked with the ACOs to set new measures. They are currently getting 2014 HEDIS/CAHPS data; plan to hold a public stakeholders meeting the beginning of 2016 to look at those.

Rylee asked how individuals can they contact someone if they are interested in learning more. Heidi said they can get additional information at https://sites.google.com/a/utah.gov/cqm/.

Russ asked when the best time would be to come back to talk about 2014 results. Heidi said they should have additional information by Spring of 2016.

Director's Report

Michael Hales gave a detailed report.

New Department of Health Executive Director

Dr. Joseph Miner was nominated by the governor and started work with the Department on 8/20. Dr. Miner was the head of the Utah County Health Department for over 30 years.

Medicaid Expansion Update

There is conceptual agreement about having the provider community pay for the majority of the state match dollars around the expansion. Federal fiscal year 2020 (State fiscal year 2020-2021) would be the first year to have full 10% burden for the State. The estimated state match necessary for the expansion is $78M; $50M is estimated for those who are newly eligible, and $28M is for individuals currently eligible but not yet enrolled. The majority of the currently eligible population is assumed to be children who would come on to the program with their parents. When there are more applications to the Marketplace, Medicaid receives more referrals.

The approach has been to engage the provider community, to look at their portion of the benefit of increased enrollment as a provider grouping, and to ask them to pay a portion of that allocation toward the expansion. UDOH is working with Milliman to review 2014 qualified health plans and the expenditures where claims were paid out. There are federal rules in place to be able to match dollars with federal participation. Looking at this will take another few weeks to evaluate where the methodologies have developed.

Steven asked how much of the $78M the State plans to come up with. Michael said those projected figures have not been made publically available at this time, but there have been discussions around the State paying for the individuals who are eligible today, but not receiving services. Providers would then be responsible for 'newly eligible' individuals.

RyLee asked what happens if we don't get buy in from providers. Michael said this may prompt additional discussions/strategies.

RyLee asked if there would be a special tax, such as a tax on e-cigs to help if providers do not pick up the cost. Michael said the preferred method would be to get the providers to pay, but it is possible to look at alternative funding sources.

Mark Brasher said there is a concern that providers might raise rates. Michael said there are already three provider assessments in place. Right now there are assessments for Skilled Nursing Facilities (SNFs), Hospitals, and Ambulances. All these groups participate in the existing Medicaid program. Overall they generally benefit as a group. There are currently no assessments for pharmacies or physicians. Not all physicians participate in the Medicaid program. CMS has three general rules for provider assessments when they're used to fund matching dollars: The program has to be uniform, broad-based, and have a hold-harmless provision. Physicians have the dynamic of being included or excluded from insurance provider panels. The disparities are greater, so it is more difficult to get a consensus. There are higher risks with certain provider groups. SNF, Hospital and Ambulance assessments do not typically have a great cost to the community at large. Increases to pharmacies, for example, would need to be broad-based to make sure that the tax is being passed on to the end consumer.

Michelle said there is a difference between taxing a corporation versus taxing an individual physician. There is a broad range of incomes among physician providers from retirees doing charity work, residents, part-time physicians, etc. so there are grave concerns about going in that direction.

Part of the model is to do an annual overview to make sure funds are being appropriately funneled.

Rylee asked if Utah is unique in not having a physician assessment. Michelle said there are no states that have a physician assessment. Only Wisconsin has had an overall tax on all professional services, including physicians, but that has only to do with budget shortfalls in that state. Arizona and Kentucky funded their entire expansion through hospital assessments.

Russ said the Tribune noted there is a proposed sales tax increase. Michael said the Tribune is most likely just voicing the discussions going on among the public, and noted that this information is not reflective of what the group is deciding. There has not been talk about how the State would fund their portion of the expansion.

Russ asked if there is agreement, would the process then be to have a special legislative session? Michael said this is possible, but no date has been set for that. Michael feels the preference would be to have a special session.

Steven said that in recent years physicians have been forced into special training for the use of controlled substances. He feels it appears to be easy to have providers foot the bill. Michelle said DEA licensing fees went up by $300 this year. Physicians are not happy that they are being taxed for various reasons.

PCN Open Enrollment Period

Currently there are 11,725 enrollees on PCN. Adults with dependent children in the home (5,567), and adults without dependent (6,158). The State is hoping to get the population of adults with children higher so we get back to the targeted distribution. If the legislature enacts a Medicaid expansion, PCN enrollees will transition to Medicaid.

CMS Request to Extend 1115 Waiver (PCN Program)

The PCN Waiver Authority runs through December, 2015. We have submitted a request to extend the waiver. Michael feels there will not be pushback on the extension from CMS. There is a public hearing scheduled on October 22 to discuss the extension.

Rylee asked about the details of the October 22 meeting. It will be held from 3:30-5:30 in Room 129. There will be a public notice going out.

Substance Abuse 1115 Waiver

CMS issued a letter in July (Medicaid Director Letter number 15-003) to State Medicaid Directors regarding new service delivery for individuals with substance use disorder. We want to be prepared to help with this population. There have been talks with CMS about how to address their needs. CMS will allow states to submit an 1115 Waiver to contemplate these needs. California has submitted a large proposal that is on the CMS website; we will look at that to see if there are items of interest to us. A few items to note: The waiver is not going to waive the inability for states to pay for incarcerated persons. CMS is willing to put federal participation into services they have not in the past. Utah is looking at

doing something like this under the expansion. Michael asked that if anyone has information to share, please do so.

Russ asked about a timeline. Michael said if anyone has information they should submit it within the next 4-6 weeks. The goal would be to have a document ready for public comment within 3-4 weeks of a special session of this committee, then there would need to be a 30 day public hearing before submitting to CMS.

Tim expressed concern about Institutions for Mental Disease (IMD) for residential programs. This is important for people who are coming out of incarceration. Michael encouraged people associated with this target group to step forward to contribute their thoughts. A Bridge Program would give an opportunity to work with this population. Michael said this population could potentially fall into the medically frail population.

Russ said what will be beneficial for the ACOs is if we initiate a good pilot. Michael reiterated the importance of getting things right from the beginning. We already know there will be changes based on individuals in certain poverty levels.

Tina asked how long an individual will stay on the waiver after they have completed a substance use program. Michael said services would be available as long as the person needed them, but their eligibility for Medicaid would not be contingent upon their status. Tina said there can be relapses - how many times would someone go through a relapse while on the waiver? Michael said it would not be limited. Jackie said substance use should be looked at as a chronic disease, so the number of treatments should not be limited. Michael envisions that we would be addressing the need, not limiting the visits.

RyLee said it is frustrating that the discussions are happening behind closed doors. This initiative seems to fit in well with the SIM integration.

Managed Care Rates

CMS still has not approved rates that were supposed to go into effect January 1, 2015. We are hopeful that they will be approved soon. The State is currently working on rates that would take effect July-December, 2015 but cannot complete that work as it hinges on the acceptance of the 1/1/2015 rates.

Updates from the Social Services Appropriations Subcommittee

The subcommittee met on September 11, 2015. A brief report on the status of the PRISM project was supplied. Updates on the provider enrollment module and claims payment system were provided.

A report was also provided on the systems of care project and its look at high cost individuals. All of the high cost individuals (>$100,000/year) had some Medicaid services. Focus of the report was to encourage the agencies to coordinate services to initiate cost savings. High cost patients included cancer, and pre-term deliveries. It was noted that coordination efforts between agencies may not be possible for these reasons but the conclusion was the greatest opportunity for savings would be between Human Services and the Division of Services for People with Disabilities (DSPD) for individuals with mental health issues and substance use disorders.

Another report was about direct service worker rate and wage increases in Intermediate Care Facilities as well as an appropriation that Human Services received for waiver providers. DOH received $200,000

with matching federal funds that were put into ICF/ID facilities. The hope is that this money will be put into reimbursing front line staff.

Medicaid Shutdown Preparedness

The core Medicaid program is funded through December 31, 2015, so there would have to be a shutdown until after that time in order for it to affect Medicaid. Michael reviewed the history of past shut downs. Congress can pass a Continuing Resolution to avoid government shut down; a full budget does not have to be approved.

CHIP is funded through September 30, 2017. Budget appropriations for CHIP are outside of normal budgeting process.

ICF/ID Program Change

ICF/ID facilities are typically at 100% occupancy level. Each year we try to offer the opportunity for individuals to move into the community. We recently tried contacting all individuals directly (instead of through a letter) to make sure they had gotten the letters in the past. We did not find any more individuals interested when using this method. We will revert back to the traditional methodology of contacting them by letter. The administrative rule for this program was amended so the Department has the discretion to use either contact methodology in the future.

Steven asked if the motivation to move individuals to the community is that they will be served better. Michael said we want the individual to receive services in the setting where they feel most comfortable. The difficulty with the population is that there are more needs than facilities available.

Other

Andrew suggested a potential agenda item for next month would be an update on where the Department is with the ruling on overtime pay for home care workers.

Adjourn

With no further business to consider, the meeting adjourned at 3:38 pm.